505 Health Blvd
Daytona Beach, Fl. 32114
386-255-5050
www.DiGaetanoCataract.com

Welcome to DiGaetano Cataract Services. We are delighted to have you as new patient. Our doctors specialize in the medical and surgical care of eyes. We are the longest established practice in the greater Daytona Beach area, preserving a tradition of providing the finest patient care available.

The enclosed forms should be filled out as completely as possible, especially your list of medications.

The appointment time below has been reserved for you. Please remember to bring with you these forms, insurance cards, identification cards and your eyeglasses to your appointment on:

_____.

We reserve the right to discharge a patient from our care if a patient "no-shows" or cancels without an advanced notice of 24 hours, on 3 or more occasions.

Dr. DiGaetano performs her surgeries at Atlantic Surgery Center. In the event you need a surgical procedure, please be aware that the surgical facility may not be an in-network facility. Please be sure to check with your insurance carrier to confirm and to also verify that you have out of network benefits. Your out of network benefits may cover the facility. If you have any questions, please contact your insurance company or the insurance department at the surgical facility.

Atlantic Surgery Center
541 Health Blvd.
Daytona Beach, Fl. 32114
386-239-0021

Thank you for choosing our office for your eye care needs. We look forward to meeting you!!

Margaret DiGaetano, M.D.
Jennifer Iannarelli, OD
Itza Acevedo, M.D.
Robert Young, M.D.
DiGaetano Cataract Services, PA

DiGaetano Cataract Services

MRN _____

Name: _____ **Nick Name:** _____ **Date:** ___/___/___

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Gender: ☐ Female ☐ Male ☐ Other **DOB:** ___/___/___ **SS#:** _____

Race: _____ **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Other: _____ ☐ Decline

Preferred Language: *(Specify)* _____ **Marital Status:** Single / Married / Divorced / Other

Home Phone: _____ **Cell Phone:** _____ **Email:** _____
(Only Used for Online Access to Health Profile)

Are you Employed? ☐ Yes ☐ No **How did you hear about our office:** _____

Do we have your permission to leave a voicemail regarding test results? ☐ Yes ☐ No

Do we have permission to advise family members of your medical status? ☐ Yes ☐ No
Emergency Contact: _____ **Relationship:** _____ **Phone:** _____
Primary Care Physician: _____ **Phone:** _____

Do you wear Glasses? ☐ No ☐ Yes, How Old Are They?____Yrs. – Where did you buy them? _____

Do you have an advanced healthcare directive or designated decision maker on file with a healthcare provider?
☐ No ☐ Yes, which provider? _____

ACTIVE CONDITIONS: Are you CURRENTLY receiving treatment for any condition(s) listed below? Check Y or N

	Y	N		Y	N
AIDS/HIV	☐	☐	Hearing Loss _____	☐	☐
Anxiety	☐	☐	Hepatitis: ***Please indicate type:*** _____	☐	☐
Arthritis	☐	☐	Hypertension	☐	☐
Asthma	☐	☐	High Cholesterol	☐	☐
Atrial Fibrillation	☐	☐	Hyperthyroidism	☐	☐
Bone Marrow Transplantation	☐	☐	Hypothyroidism	☐	☐
BPH (Benign Prostatic Hyperplasia)	☐	☐	Leukemia	☐	☐
Breast Cancer ***(currently receiving treatment)***	☐	☐	Lung Cancer ***(currently receiving treatment)***	☐	☐
Colon Cancer ***(currently receiving treatment)***	☐	☐	Lymphoma	☐	☐
COPD	☐	☐	Prostate Cancer ***(currently receiving treatment)***	☐	☐
Coronary Artery Disease	☐	☐	Radiation Treatment	☐	☐
Depression	☐	☐	Seizures	☐	☐
Diabetes	☐	☐	Stroke	☐	☐
End Stage Renal Disease	☐	☐	**Other medical conditions not listed?**		
GERD	☐	☐			

PAST SURGICAL HISTORY: Have you ever had any of the following surgeries? Check Y or N

	Y	N		Y	N
Appendix Removal (Appendectomy)	☐	☐	Kidney Stone Removal	☐	☐
Bladder Removal (Cystectomy)	☐	☐	Kidney (Nephrectomy)	☐	☐
Mastectomy (Left, Right, Bilateral)	☐	☐	Joint Replacement, Knee (Right, Left, Bilateral)	☐	☐
Lumpectomy (Left, Right, Bilateral)	☐	☐	Joint Replacement, Hip (Right, Left, Bilateral)	☐	☐
Breast Biopsy (Left, Right, Bilateral)	☐	☐	Spleen Removal (Splenectomy)	☐	☐
Breast Reduction	☐	☐	Prostate (Prostatectomy)	☐	☐
Breast Implants	☐	☐	TURP (transurethral resection of the prostate)	☐	☐
Gallbladder Removal (Cholecystectomy)	☐	☐	Skin Biopsy	☐	☐
Coronary Artery Bypass	☐	☐	Hysterectomy	☐	☐
(PTCA) Percutaneous transluminal coronary angioplasty	☐	☐	Heart Valve Replacement	☐	☐

Transplant History (check all that apply)

☐ Heart ☐ Liver ☐ Kidney ☐ Pancreas

Other surgeries not listed?

OCULAR HISTORY: Have you ever had any of the following conditions? Check Y or N					
	Y	N		Y	N
Allergic Conjunctivitis	☐	☐	Pseudo Exfoliation	☐	☐
Blepharitis	☐	☐	Diabetic Retinopathy (Left, Right)	☐	☐
Cataract (Left, Right)	☐	☐	Strabismus (crossed eye or wall eye)	☐	☐
Cornea dystrophy (Left, Right)	☐	☐	Macular Degeneration (Left, Right)	☐	☐
Glaucoma (Left, Right)	☐	☐	Retinal Tear (Left, Right)	☐	☐
Macular pucker or wrinkle (Left, Right)	☐	☐	Vitreous Floaters (Left, Right)	☐	☐
Dry Eyes	☐	☐	PVD (Left, Right)	☐	☐
Ophthalmic Migraine	☐	☐	Ocular Hypertension (Left, Right)	☐	☐
Narrow Angles (Left, Right)	☐	☐			
OCULAR SURGICAL HISTORY: Have you ever had any of the following surgeries? Check Y or N					
	Y	N		Y	N
Blepharoplasty (Left, Right)	☐	☐	Cataract Surgery (Left, Right)	☐	☐
Corneal Transplant (Left, Right)	☐	☐	Eye Muscle Surgery (Left, Right)	☐	☐
DSAEK: Cornea (Left, Right)	☐	☐	Intravitreal Injections (Left, Right)	☐	☐
LASIK, PRK, RK or other refractive surgery (Left, Right)	☐	☐	Trabeculectomy or glaucoma surgery (Left, Right)	☐	☐
Glaucoma Laser (Left, Right)	☐	☐	Peripheral iridotomy Laser (Left, Right)	☐	☐
Ptosis i.e. droopy eyelid Repair (Left, Right)	☐	☐	Punctal Plugs (Left, Right)	☐	☐
YAG laser Capsulotomy (Left, Right)	☐	☐	Retinal Laser (Left, Right)	☐	☐

************ VERY IMPORTANT THAT AREA BELOW IS FILLED OUT COMPLETELY ************

PLEASE LIST ALL MEDICATIONS - PRESCRIPTION AND OVER THE COUNTER		
Medication Name	**Dose/Strength**	**How Often**
Example: Aspirin	***81mg***	***1/day***

Preferred Pharmacy: _____ Phone: _____

Address/ City/Zip: _____

Primary Insurance Carrier:_____ Name of Insured (Subscriber): _____

Subscriber DOB: ___/___/____ Subscriber Gender: ☐ Male ☐ Female Relationship to patient: _____

PLEASE LIST ALL MEDICATION ALLERGIES – OR – MARK "NO KNOWN ALLERGIES" BOX	

☐ No Known Allergies

Social History:			
	Y	N	
Do you smoke Cigarettes?	☐	☐	If No, are you a Former Smoker ☐ or Never Smoker ☐
Did you have a Pneumonia Vaccination?	☐	☐	If yes, when? ___/_____ (mm/yy)
Did you receive an Influenza (aka "flu") shot?	☐	☐	If yes, when? ___/_____ (mm/yy)
Are you allergic to Latex?	☐	☐	
Do you feel safe at home?	☐	☐	

How many alcoholic beverages do you consume on an average day?

☐ None ☐ 0 - 1 Drink ☐ 1 - 2 Drinks ☐ 3 or more Drinks

Men, age 64 and younger: How many times in the past year have you had 5 or more drinks in a day? _____

All Women and Men 65 and older: How many times in the past year have you had 4 or more drinks in a day for women or any adult older than 65? _____

FAMILY HISTORY: Is there any family history of the following? Check Y or N. In the corresponding area indicate (Mother, Father, Sister, Brother, Grandparent)			
	Y	N	Relative
Cancer	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Thyroid	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Retinal Detachment	☐	☐	
Strabismus (Lazy Eye)	☐	☐	
Family History of Other Medical Conditions not listed?			

CONSENT TO OBTAIN MEDICATION HISTORY

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your medication history. A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important in helping us treat you properly and in avoiding potentially dangerous drug interactions. By signing this consent form you give us permission to collect and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become a part of your medical record. The medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you have purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history**. I give permission for DiGaetano Cataract Services to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.**

Signature _____ **Date:** _____

PAYMENT OF BENEFITS/ AUTHORIZATION OF TREATMENT

I hereby authorize treatment from any licensed medical professional within DiGaetano Cataract Services, PA. I understand that this authorization may be used now or in the future. PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. We accept VISA, MasterCard, AMEX and DISCOVER for your convenience. Your signature below indicates that you understand and accept this policy. I request the direct payment of all authorized medical benefits to be made to DiGaetano Cataract Services, PA for any services I received by the physicians of DiGaetano Cataract Services, PA. I authorize any holder of medical information about me to release this information to process my claims or meet legal requirements. I permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked, in writing. I understand that because these services were performed for me or my legal dependent, I am financially responsible for all charges incurred. DiGaetano Cataract Services, PA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Signature:_____ Date: ____/____/_____

OFFICE POLICIES

Please read carefully, if you have any questions regarding our office policies do not hesitate to ask!!

DRIVING POLICY

Dilating drops enlarge the pupils of the eye to allow for the examination of the inside of your eye. These drops usually cause blurred vision. **After an examination with dilating drops, you should not drive yourself. Instead, you should make alternative arrangements for transportation after your examination**. If you do choose to drive yourself, you acknowledge that you understand the risks and accept full responsibility for any injuries to yourself or others.
Adverse reaction, such as acute angle-closure glaucoma may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical treatment.
You hereby authorize the doctors of DiGaetano Cataract Services and/or their assistants to administer dilating eye drops during your treatment.

I have read and understood the above paragraphs **Patient Initials**_____

INSURANCE POLICY

Your insurance policy is a contract between you and your insurance company. We accept Medicare assignment and will file claims with certain medical plans**.** Claims will be filed based on the information you give us. To file an insurance claim for you, we must make a copy of your insurance card. In the event a claim is denied, or should payment not be received within 45 days of claim submission, we will refile the claim one time. Please call your insurance company if you are not certain we participate with your plan. As a subscriber of your insurance, it is your responsibility to be aware of the limitations and conditions of your policy. **Patients are responsible for any co-pays and/or deductibles. Payment is due at the time of service unless prior arrangements are made.**

I have read and understood the above paragraph **Patient Initials**_____

APPOINTMENT POLICY

We have reserved an appointment time for you. If you are not able to make your appointment, please contact the office at your earliest convenience. This will allow us to schedule another patient, in need of our care, to see one of our qualified eye Doctors on an earlier date. If you have a scheduled appointment and you do not show to that appointment or contact our office 24 hours in advance, you will be charged a fee of **$30.00.** Our office reserves the right to discharge a patient from our care, when 3 or more appointments have been missed with no communication or cancellations without prior notification.

I have read and understood the above paragraphs **Patient Initials**_____

REFRACTION POLICY

A refraction is a test / procedure ordered by the physician to assist them in determining what your best vision is with lenses and if your vision can be improved with corrective lenses. If your vision cannot be corrected with a prescription for corrective lenses, it may indicate a problem with the health of your eyes. It can also be used to detect certain types of vision loss.

We want to make you, the patient, aware of the $40.00 fee for this test to be completed. We will file a claim to your insurance carrier on your behalf, but Medicare and some other insurance plans state this is a non-covered service. Therefore, this fee would be the patient's responsibility.

WHY IS THE REFRACTION CHARGED AND NOT COVERED?

Medicare and certain insurance companies do not consider a refraction a medical service. They (Medicare) acknowledges that this test / procedure is separate to the rest of the eye exam and therefore there is a separate fee.

I have read and understood the above paragraph **Patient Initials_____**

I acknowledge that the facts provided on this registration are true and correct. I also understand it is my responsibility to notify the office of any personal or insurance changes. I understand the privacy practices are posted and a copy is available at my request.

I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from insurance including Medicare.
I authorize DiGaetano Cataract Services to correspond via email address given above.

Patient Signature: _____ Date: _____
(or Guardian's signature if patient is a minor)

THANK YOU FOR ALLOWING US THE OPPORTUNITY TO CARE FOR YOUR EYES!